

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXXX

Petitioner

v

File No. 122115-001

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 28th day of November 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On June 29, 2011, XXXXX (Petitioner) filed a request with the Commissioner of Financial and Insurance Regulation for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner reviewed the request and accepted it on July 7, 2011.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on July 18, 2011.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM *Community Blue Group Benefits Certificate* (the certificate) and rider *CBD \$2,000-NP Community Blue Deductible Requirement for Nonpanel Services* (the rider) which amends the certificate. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

On March 15, 2011, the Petitioner had a lesion removed from his mouth by XXXXX, DDS, of XXXXX Associates. Dr. XXXXX sent the specimen to a Dr. XXXXX for pathology testing. Dr. XXXXX is a nonpanel provider.¹ BCBSM covered the pathology service but applied its approved amount of \$150.00 to Petitioner's nonpanel deductible.

The Petitioner appealed BCBSM's processing of the claim. BCBSM held a managerial-level conference on June 14, 2011, and issued its final adverse determination dated June 16, 2011, upholding its decision.

III. ISSUE

Did BCBSM correctly process the Petitioner's claim for the pathology service?

IV. ANALYSIS

Petitioner's Argument

The Petitioner states he had no control over Dr. XXXXX's decision to send the specimen to a nonpanel provider. He also argues that Dr. XXXXX sent a referral form to Dr. XXXXX as required by the certificate and therefore the nonpanel deductible should not apply.

In a "To Whom It May Concern" letter dated April 26, 2011, Dr. XXXXX's office wrote:

When the biopsy was done the [Petitioner] has no control over where it's sent.
When the paperwork was sent to LSU we sent the BCBS PPO trust referral form
showing that the [Petitioner] was referred by an in network doctor.

The Petitioner's wants BCBSM to waive the nonpanel deductible for the pathology service.

BCBSM's Argument

In its final adverse determination of June 16, 2011, BCBSM explained its determination:

[We] must maintain the out-of-network deductible applied to Dr. XXXXX's
pathology service. Your coverage includes Rider CBD \$2000-NP which amends

¹ A nonpanel provider is a hospital, physician, or other licensed facility or health care professional who has not signed an agreement to provide services under the Petitioner's PPO program.

your certificate and requires you to pay a deductible of \$2,000 for one member (\$4,000,00 for the family) for most covered services provided by nonpanel (non PPO) providers.

The rider explains when the nonpanel deductible does not apply:

You are not required to pay a deductible for covered nonpanel services when:

- A panel provider refers you to a nonpanel provider
NOTE: You must obtain the referral **before** receiving the referred service or the service will be subject to nonpanel deductible requirements.
- You receive services for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- You receive services from a provider that has no PPO panel
- You receive services from a nonpanel provider in a geographic area in Michigan deemed a "low access area" by BCBSM for that particular provider specialty

The final adverse determination went on to explain why the exceptions did not apply in the Petitioner's case:

A referral was not submitted with Dr. XXXXX's claim. I spoke with staff at the provider's office and confirmed they did not have record of a referral. Furthermore, because Dr. XXXXX is not a panel (PPO) provider, a referral from Dr. XXXXX to Dr. XXXXX does not waive the nonpanel deductible. Thus, the nonpanel deductible applied of \$150 is correct and remains your responsibility.

BCBSM believes its application of the nonpanel deductible was appropriate because there was no referral to Dr. XXXXX from a panel provider.

Commissioner's Review

The language of the rider is clear: the Petitioner must satisfy a deductible before BCBSM is required to make its payment for covered services from nonpanel providers. It is undisputed that the Petitioner received a service (pathology testing) from a nonpanel provider. Therefore, BCBSM was correct in applying its approved amount for Dr. XXXXX's services to the nonpanel deductible.

In this case, the Petitioner's lesion was removed by a nonpanel provider and the specimen was sent to another nonpanel provider for testing. Because Dr. XXXXX is not a panel provider, he cannot make a referral that would waive the nonpanel deductible for Dr. XXXXX's

services. Moreover, none of the other exceptions that would waive the nonpanel deductible apply here.

The Petitioner also indicates that he had no control over where Dr. XXXXX sent the specimen for testing. While that may be true, there is nothing in the certificate or the rider that requires the nonpanel deductible to be waived in such circumstance.

The Commissioner finds that BCBSM correctly applied the nonpanel deductible in compliance with the rider.

V. ORDER

Blue Cross Blue Shield of Michigan's final adverse determination of June 16, 2011, is upheld. BCBSM is not required to waive the nonpanel deductible applied to Petitioner's pathology service.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

R. Kevin Clinton
Commissioner